Patient Registration Form

Please complete both sides & return to reception. Thank you.

ARTHROhealth

Personal Details

Title: ❑ Mr ❑ Mrs ❑ Ms ❑ Dr ❑ Other:_____ **Date of Birth:**_____

First Name:_____ **Surname:**_____

Street Address:_____

Suburb:_____ **Post Code:**_____

Postal Address (if different from above):_____

_____

Email address:_____@_____

Occupation:_____

Home:_____ Work:_____ Mobile:_____

Next of Kin:_____ Relationship:_____ Contact:_____

Claim Details (please complete applicable sections)

Medicare: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Ref No: _____ Exp:_____/_____

Private Health Insurer:_____

Member No: _____ Ref No: _____

Veterans Affairs Card Number: ___ ___ ___ ___ ___ ___ ___ ___ ❑ Gold ❑ White

WorkCover/TAC Details:

Date of Accident:_____ Claim No:_____

Insurer:_____ Case Manager:_____

Contact No:_____ Fax:_____

Email:_____@_____

Referral Details (please provide details of the following professionals for us to forward correspondence)

Referring Doctor:_____

Address:_____Tel:_____

Usual Family Doctor: *(if different from above)* _____

Address:_____Tel:_____

Usual Physiotherapist/Allied Health Professional:_____

Address:_____Tel:_____

Please turn over….

Referral Source (how did you hear about ARTHRO Health & our surgeons)

Website:_____

Personal recommendation:_____

Other:_____

Medical Questionnaire (please mark & provide details for all which apply)

☐ Smoker: _____ ☐ Lung Disease: _____

☐ Allergies: _____ ☐ Diabetes: _____

☐ DVT/PE: _____ ☐ Kidney Disease:_____

☐ Heart Disease (eg: AMI, cardiac failure): _____ _____

☐ Height: _____cms ☐ Weight: _____ kgs ☐ BMI:_____
(office use only)

Other Medical Conditions: _____

_____

_____

Current Medications: _____

_____

_____

Previous Operations, admissions to hospital or serious illnesses (please list including date/year):

_____

_____

_____

Privacy Policy

From December 21, 2001, the Federal Privacy Act of 1988 was amended to apply to all doctors in private practice. It is required that a fully informed voluntary consent is obtained before or as soon as practical after the collection of health information. Medical care requires a full knowledge of patient health information by all members of a medical team, which may be shared from time to time, including by electronic means. This may include referring doctors, pathology, radiology, anaesthetists, Medicare, private health funds and debt collections agencies. Health information may be used for 'secondary purposes' such as auditing surgical results, clinical research, etc. Record keeping may also include medical imaging and photographs. The privacy of individuals is strictly maintained when reporting results of audits or research to the profession.

I (print name)_____have read and understood the above and consent to information, medical imaging and photographs being used for the secondary purpose of audit and research by ARTHRO Health, their providers and associates. I also consent to medical records and medical imaging being destroyed after seven years if I am no longer being treated at ARTHRO Health by their providers.

Signed:_____ Date:_____

If guardian, relationship to patient:_____

Consultation fees (for all patients including WorkCover/TAC) are expected to be paid in full at the time of your appointment. These fees are above the Medicare Benefits Schedule (MBS) fee. You will be able to claim the MBS benefit from Medicare with the receipt issued if you have a **valid GP/Specialist referral**. All WorkCover/TAC patients will need to claim from the applicable party with the receipt issued.

Please return completed for to reception. Thank you